NOTICES OF PROPOSED RULEMAKING

Unless exempted by A.R.S. § 41-1005, each agency shall begin the rulemaking process by first submitting to the Secretary of State's Office a Notice of Rulemaking Docket Opening followed by a Notice of Proposed Rulemaking that contains the preamble and the full text of the rules. The Secretary of State's Office publishes each Notice in the next available issue of the *Register* according to the schedule of deadlines for *Register* publication. Under the Administrative Procedure Act (A.R.S. § 41-1001 et seq.), an agency must allow at least 30 days to elapse after the publication of the Notice of Proposed Rulemaking in the *Register* before beginning any proceedings for making, amending, or repealing any rule. (A.R.S. §§ 41-1013 and 41-1022)

NOTICE OF PROPOSED RULEMAKING

TITLE 9. HEALTH SERVICES

CHAPTER 22. ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM ADMINISTRATION

[R07-105]

PREAMBLE

1. **Sections Affected** / **Rulemaking Action**

R9-22-101	Amend
R9-22-102	Repeal
R9-22-201	Repeal
R9-22-201	New Section
R9-22-202	New Section
R9-22-217	Amend

2. **The statutory authority for the rulemaking, including both the authorizing statute (general) and the statutes the rules are implementing (specific):**

Authorizing statute: A.R.S. § 36-2903.01(F)

Implementing statute: A.R.S. §§ 36-2901(6)(ii), 36-2903.03(D) and (F)

3. **A list of all previous notices appearing in the *Register* addressing the proposed rule:**

Notice of Rulemaking Docket Opening: 12 A.A.R. 1099, April 7, 2006

4. **The name and address of agency personnel with whom persons may communicate regarding the rulemaking:**

Name: Mariaelena Ugarte

Address: AHCCCS
Office of Legal Assistance
701 E. Jefferson, Mail Drop 6200
Phoenix, AZ 85034

Telephone: (602) 417-4693

Fax: (602) 253-9115

E-mail: AHCCCSRules@azahcccs.gov

5. **An explanation of the rule, including the agency's reasons for initiating the rule:**

The following rule has been proposed to comply with a recent Consent Decree regarding the coverage of emergency dialysis services for members of the Federal Emergency Services Program (FES).

6. **A reference to any study that the agency proposes to rely on in its evaluation of or justification for the rules and where the public may obtain or review the study, all data underlying each study, any analysis of the study, and other supporting material:**

No study was reviewed.

7. **A showing of good cause why the rule is necessary to promote a statewide interest if the rule will diminish a previous grant of authority of a political subdivision of this state:**

Not applicable

8. **The preliminary summary of the economic, small business, and consumer impact:**

It is anticipated that there will be a minimal economic impact, since the emergency dialysis services have been covered for several years as a result of this lawsuit.

9. The name and address of agency personnel with whom persons may communicate regarding the accuracy of the economic, small business, and consumer impact statement:

Name: Mariaelena Ugarte

Address: AHCCCS
Office of Legal Assistance
701 E. Jefferson, Mail Drop 6200
Phoenix, AZ 85034

Telephone: (602) 417-4693

Fax: (602) 253-9115

E-mail: AHCCCSRules@azahcccs.gov

Proposed rule language will be available on the AHCCCS web site www.azahcccs.gov the week of April 2, 2007. Please send written comments to the above address by 5:00 p.m., May 21, 2007. E-mail comments will also be accepted during this time-frame.

10. The time, place, and nature of the proceedings for the making, amendment, or repeal of the rule, or if no proceeding is scheduled, where, when, and how persons may request an oral proceeding on the proposed rule:

Date: May 21, 2007
Time: 10:00 a.m.
Location: AHCCCS
701 E. Jefferson
Phoenix, AZ 85034
Nature: Public Hearing

Date: May 21, 2007
Time: 10:00 a.m.
Location: ALTCS: Arizona Long-term Care System
110 S. Church, Ste. 1360
Tucson, AZ 85701
Nature: Public Hearing

Date: May 21, 2007
Time: 10:00 a.m.
Location: ALTCS: Arizona Long-term Care System
3480 E. Rte. 66
Flagstaff, AZ 86004
Nature: Public Hearing

11. Any other matters prescribed by statute that are applicable to the specific agency or to any specific rule or class of rules:

None

12. Incorporations by reference and their location in the rules:

None

The full text of the rules follows:

TITLE 9. HEALTH SERVICES

CHAPTER 22. ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM ADMINISTRATION

ARTICLE 1. DEFINITIONS

Section
R9-22-101. Location of Definitions
R9-22-102. ~~Scope of Services-related Definitions~~ Repealed

ARTICLE 2. SCOPE OF SERVICES

Section
R9-22-201. ~~General Requirements~~ Scope of Services-related Definitions
R9-22-202. ~~Repealed~~ General Requirements
R9-22-217. Services Included in the Federal Emergency Services Program

ARTICLE 1. DEFINITIONS

R9-22-101. Location of Definitions

A. Location of definitions. Definitions applicable to this Chapter are found in the following:

Definition	Section or Citation
"Accommodation"	R9-22-701
"Act"	R9-22-101
"ADHS"	~~R9-22-102~~ R9-22-101
"Administration"	A.R.S. § 36-2901
"Adverse action"	R9-22-101
"Affiliated corporate organization"	R9-22-101
"Aged"	42 U.S.C. 1382c(a)(1)(A) and R9-22-1501
"Aggregate"	R9-22-701
"AHCCCS"	R9-22-101
"AHCCCS inpatient hospital day or days of care"	R9-22-701
"AHCCCS registered provider"	R9-22-101
"Ambulance"	A.R.S. § 36-2201
"Ancillary department"	R9-22-701
"Annual enrollment choice"	R9-22-117
"APC"	R9-22-701
"Appellant"	R9-22-101
"Applicant"	R9-22-101
"Application"	R9-22-101
"Assignment"	R9-22-101
"Attending physician"	R9-22-101
"Authorized representative"	R9-22-101
"Auto-assignment algorithm"	R9-22-117
"Baby Arizona"	R9-22-1401
"Behavior management services"	R9-22-1201
"Behavioral health adult therapeutic home"	R9-22-1201
"Behavioral health therapeutic home care services"	R9-22-1201
"Behavioral health evaluation"	R9-22-1201
"Behavioral health medical practitioner"	R9-22-1201
"Behavioral health professional"	R9-22-1201
"Behavioral health recipient"	~~R9-22-102~~ R9-22-201
"Behavioral health service"	R9-22-1201
"Behavioral health technician"	R9-22-1201
"BHS"	R9-22-1401
"Billed charges"	R9-22-701
"Blind"	R9-22-1501
"Burial plot"	R9-22-1401
"Capital costs"	R9-22-701

"Capped fee-for-service"	R9-22-101
"Caretaker relative"	R9-22-1401
"Case management"	R9-22-1201
"Case record"	R9-22-101
"Case review"	R9-22-101
"Cash assistance"	R9-22-1401
"Categorically-eligible"	R9-22-101
"Certified psychiatric nurse practitioner"	R9-22-1201
"Children's Rehabilitative Services" or "CRS"	~~R9-22-102~~ R9-22-201
"Clean claim"	A.R.S. § 36-2904
"Clinical supervision"	~~R9-22-102~~ R9-22-201
"CMDP"	R9-22-117
"CMS"	R9-22-101
"Continuous stay"	R9-22-101
"Contract"	R9-22-101
"Contractor"	A.R.S. § 36-2901
"Cost-To-Charge Ratio"	R9-22-701
"Covered charges"	R9-22-701
"Covered services"	~~R9-22-102~~ R9-22-101
"CPT"	R9-22-701
"Critical Access Hospital"	R9-22-701
"Cryotherapy"	R9-22-2001
"Date of eligibility posting"	R9-22-701
"Day"	R9-22-101
"DBHS"	~~R9-22-102~~ R9-22-201
"DCSE"	R9-22-1401
"De novo hearing"	42 CFR 431.201
"Dentures and "Denture services"	~~R9-22-102~~ R9-22-201
"Department"	A.R.S. § 36-2901
"Dependent child"	A.R.S. § 46-101
"DES"	R9-22-101
"Diagnostic services"	~~R9-22-102~~ R9-22-101
"Director"	R9-22-101
"Disabled"	R9-22-1501
"Discussion"	R9-22-101
"Disenrollment"	R9-22-117
"DME"	~~R9-22-102~~ R9-22-101
"DRI inflation factor"	R9-22-701
"E.P.S.D.T. services"	42 CFR 440.40(b)
"Eligible person"	A.R.S. § 36-2901
"Emergency behavioral health condition for the non-FES member"	~~R9-22-102~~ R9-22-201
"Emergency behavioral health services for the non-FES member"	~~R9-22-102~~ R9-22-201
"Emergency medical condition for the non-FES member"	~~R9-22-102~~ R9-22-201
"Emergency medical services for the non-FES member"	~~R9-22-102~~ R9-22-201
"Emergency medical or behavioral health condition	

for a FES member"	R9-22-217
"Emergency services costs"	A.R.S. § 36-2903.07
"Encounter"	R9-22-701
"Enrollment"	R9-22-117
"Enumeration"	R9-22-101
"Equity"	R9-22-101
"Experimental services"	R9-22-101
"Existing outpatient service"	R9-22-701
"FAA"	R9-22-1401
"Facility"	R9-22-101
"Factor"	R9-22-701 and 42 CFR 447.10
"FBR"	R9-22-101
"Federal financial participation" or "FFP"	42 CFR 400.203
"Federal poverty level" or "FPL"	A.R.S. § 36-2981
"Fee-For-Service" or "FFS"	~~R9-22-102~~ R9-22-101
"FES member"	~~R9-22-102~~ R9-22-101
"FESP"	R9-22-101
"First-party liability"	R9-22-1001
"Foster care maintenance payment"	42 U.S.C. 675(4)(A)
"FQHC"	R9-22-101
"Free Standing Children Hospital"	R9-22-701
"Global Insights Prospective Hospital Market Basket"	R9-22-701
"Grievance"	R9-34-202
"GSA"	R9-22-101
"HCPCS"	R9-22-701
"Health care practitioner"	R9-22-1201
"Hearing aid"	~~R9-22-102~~ R9-22-201
"HCPCS"	R9-22-701
"HIPAA"	R9-22-701
"Home health services"	~~R9-22-102~~ R9-22-201
"Homebound"	R9-22-1401
"Hospital"	R9-22-101
"Intermediate Care Facility for the Mentally Retarded" or "ICF-MR"	42 ~~USC~~ U.S.C. 1396d(d)
"ICU"	R9-22-701
"IHS"	R9-22-117
"IMD" or "Institution for Mental Diseases"	42 CFR 435.1010 and ~~R9-22-102~~ R9-22-201
"Income"	R9-22-1401
"Inmate of a public institution"	42 CFR 435.1010
"Interested party"	R9-22-101
"Legal representative"	R9-22-101
"Level I trauma center"	R9-22-2101
"License" or "licensure"	R9-22-101
"Liquid assets"	R9-22-1401
"Mailing date"	R9-22-101
"Medical education costs"	R9-22-701

"Medical expense deduction" or "MED"	R9-22-1401
"Medical record"	R9-22-101
"Medical review"	R9-22-701
"Medical services"	A.R.S. § 36-401
"Medical supplies"	~~R9-22-102~~ R9-22-201
"Medical support"	R9-22-1401
"Medically necessary"	R9-22-101
"Medicare claim"	R9-22-101
"Medicare HMO"	R9-22-101
"Member"	A.R.S. § 36-2901
"Mental disorder"	A.R.S. § 36-501
"National Standard code sets"	R9-22-701
"New hospital"	R9-22-701
"NICU"	R9-22-701
"Noncontracting provider"	A.R.S. § 36-2901
"Non-FES member"	~~R9-22-102~~ R9-22-201
"Non-IHS Acute Hospital"	R9-22-701
"Nonparent caretaker relative"	R9-22-1401
"Nursing facility" or "NF"	42 U.S.C. 1396r(a)
"Occupational therapy"	~~R9-22-102~~ R9-22-201
"Offeror"	R9-22-101
"Operating costs"	R9-22-701
"Organized health care delivery system"	R9-22-701
"Outlier"	R9-22-701
"Outpatient hospital service"	R9-22-701
"Ownership change"	R9-22-701
"Ownership interest"	42 CFR 455.101
"Partial Care"	R9-22-1201
"Peer group"	R9-22-701
"Pharmaceutical service"	~~R9-22-102~~ R9-22-201
"Physical therapy"	~~R9-22-102~~ R9-22-201
"Physician"	~~R9-22-102~~ R9-22-101
"Physician assistant"	R9-22-1201
"Post-stabilization services"	~~R9-22-102~~ R9-22-201 or 42 CFR 422.113
"Practitioner"	~~R9-22-102~~ R9-22-101
"Pre-enrollment process"	R9-22-1401
"Prescription"	~~R9-22-102~~ R9-22-101
"Primary care provider (PCP)"	~~R9-22-102~~ R9-22-101
"Primary care provider services"	~~R9-22-102~~ R9-22-201
"Prior authorization"	~~R9-22-102~~ R9-22-101
"Prior period coverage" or "PPC"	R9-22-101
"Procedure code"	R9-22-701
"Proposal"	R9-22-101
"Prospective rates"	R9-22-701
"Psychiatrist"	R9-22-1201
"Psychologist"	R9-22-1201

"Psychosocial rehabilitation services"	~~R9-22-102~~ R9-22-201
"Public hospital"	R9-22-701
"Qualified alien"	A.R.S. § 36-2903.03
"Quality management"	R9-22-501
"Radiology"	~~R9-22-102~~ R9-22-101
"RBHA" or "Regional Behavioral Health Authority"	~~R9-22-102~~ R9-22-201
"Rebase"	R9-22-701
"Referral"	R9-22-101
"Rehabilitation services"	~~R9-22-102~~ R9-22-101
"Reinsurance"	R9-22-701
"Remittance advice"	R9-22-701
"Residual functional deficit"	~~R9-22-102~~ R9-22-201
"Resources"	R9-22-1401
"Respiratory therapy"	~~R9-22-102~~ R9-22-201
"Respite"	R9-22-1201
"Responsible offeror"	R9-22-101
"Responsive offeror"	R9-22-101
"Revenue Code"	R9-22-701
"Review"	R9-22-101
"Review month"	R9-22-101
"RFP"	R9-22-101
"Scope of services"	~~R9-22-102~~ R9-22-201
"Section 1115 Waiver"	A.R.S. § 36-2901
"Service location"	R9-22-101
"Service site"	R9-22-101
"SOBRA"	R9-22-101
"Specialist"	~~R9-22-102~~ R9-22-101
"Specialty facility"	R9-22-701
"Speech therapy"	~~R9-22-102~~ R9-22-201
"Spendthrift restriction"	R9-22-1401
"Spouse"	R9-22-101
"SSA"	42 CFR 1000.10
"SSI"	42 CFR 435.4
"SSN"	R9-22-101
"Stabilize"	42 U.S.C. 1395dd
"Standard of care"	R9-22-101
"Sterilization"	~~R9-22-102~~ R9-22-201
"Subcontract"	R9-22-101
"Submitted"	A.R.S. § 36-2904
"Substance abuse"	~~R9-22-102~~ R9-22-201
"SVES"	R9-22-1401
"Third-party"	R9-22-1001
"Third-party liability"	R9-22-1001
"Tier"	R9-22-701
"Tiered per diem"	R9-22-701
"Title IV-D"	R9-22-1401

"Title IV-E"	R9-22-1401
"Trauma and Emergency Services Fund"	A.R.S. § 36-2903.07
"TRBHA" or "Tribal Regional Behavioral Health Authority"	R9-22-1201
"Tribal Facility"	A.R.S. § 36-2981
"Unrecovered trauma center readiness costs"	R9-22-2101
"Utilization management"	R9-22-501
"WWHP"	R9-22-2001

B. General definitions. In addition to definitions contained in A.R.S. § 36-2901, the words and phrases in this Chapter have the following meanings unless the context explicitly requires another meaning:

"Act" means the Social Security Act.

"ADHS" means the Arizona Department of Health Services.

"Adverse action" means an action taken by the Department or Administration to deny, discontinue, or reduce medical assistance.

"Affiliated corporate organization" means any organization that has ownership or control interests as defined in 42 CFR 455.101, and includes a parent and subsidiary corporation.

"AHCCCS" means the Arizona Health Care Cost Containment System, which is composed of the Administration, contractors, and other arrangements through which health care services are provided to a member.

"AHCCCS registered provider" means a provider or noncontracting provider who:

Enters into a provider agreement with the Administration under R9-22-703(A), and

Meets license or certification requirements to provide covered services.

"Appellant" means an applicant or member who is appealing an adverse action by the Department or Administration.

"Applicant" means a person who submits or whose authorized representative submits, a written, signed, and dated application for AHCCCS benefits.

"Application" means an official request for AHCCCS medical coverage made under this Chapter.

"Assignment" means enrollment of a member with a contractor by the Administration.

"Attending physician" means a licensed allopathic or osteopathic doctor of medicine who has primary responsibility for providing or directing preventive and treatment services for a Fee-For-Service member.

"Authorized representative" means a person who is authorized to apply for medical assistance or act on behalf of another person.

"Capped fee-for-service" means the payment mechanism by which a provider of care is reimbursed upon submission of a valid claim for a specific covered service or equipment provided to a member. A payment is made in accordance with an upper, or capped, limit established by the Director. This capped limit can be either a specific dollar amount or a percentage of billed charges.

"Case record" means an individual or family file retained by the Department that contains all pertinent eligibility information, including electronically stored data.

"Case review" means the Administration's evaluation of an individual's or family's circumstances and case record in a review month.

"Categorically-eligible" means a person who is eligible under A.R.S. §§ 36-2901(6)(a)(i), (ii), or (iii) or 36-2934.

"CMS" means the Centers for Medicare and Medicaid Services.

"Continuous stay" means a period during which a member receives inpatient hospital services without interruption beginning with the date of admission and ending with the date of discharge or date of death.

"Contract" means a written agreement entered into between a person, an organization, or other entity and the Administration to provide health care services to a member under A.R.S. Title 36, Chapter 29, and this Chapter.

"Covered services" means the health and medical services described in Articles 2 and 12 of this Chapter as being eligable for reimbursement by AHCCCS.

"Day" means a calendar day unless otherwise specified.

"DES" means the Department of Economic Security.

"Diagnostic services" means services provided for the purpose of determining the nature and cause of a condition, illness, or injury.

"Director" means the Director of the Administration or the Director's designee.

"Discussion" means an oral or written exchange of information or any form of negotiation.

"DME" means durable medical equipment, which is an item or appliance that can withstand repeated use, is designed to serve a medical purpose, and is not generally useful to a person in the absence of a medical condition, illness, or injury.

"Enumeration" means the assignment of a nine-digit identification number to a person by the Social Security Administration.

"Equity" means the county assessor full cash value or market value of a resource minus valid liens, encumbrances, or both.

"Experimental services" means services that are associated with treatment or diagnostic evaluation and that are not generally and widely accepted as a standard of care in the practice of medicine in the United States unless:

The weight of the evidence in peer-reviewed articles in medical journals published in the United States supports the safety and effectiveness of the service; or

In the absence of peer-reviewed articles, for services that are rarely used, novel, or relatively unknown in the general professional medical community, the weight of opinions from specialists who provide the service attests to the safety and effectiveness of the service.

"Facility" means a building or portion of a building licensed or certified by the Arizona Department of Health Services as a health care institution under A.R.S. Title 36, Chapter 4, to provide a medical service, a nursing service, or other health care or health-related service.

"FBR" means Federal Benefit Rate, the maximum monthly Supplemental Security Income payment rate for a member or a married couple.

"Fee-For-Service" or "FFS" means a method of payment by the AHCCCS Administration to a registered provider on an amount-per-service basis for a member not enrolled with a contractor.

"FES member" means a person who is eligible to receive emergency medical and behavioral health services through the FESP under R9-22-217.

"FESP" means the federal emergency services program under R9-22-217 which covers services to treat an emergency medical or behavioral health condition for a member who is determined eligible under A.R.S. § 36-2903.03(D).

"FQHC" means federally qualified health center.

"GSA" means a geographical service area designated by the Administration within which a contractor provides, directly or through a subcontract, a covered health care service to a member enrolled with the contractor.

"Hospital" means a health care institution that is licensed as a hospital by the Arizona Department of Health Services under A.R.S. Title 36, Chapter 4, Article 2, and certified as a provider under Title XVIII of the Social Security Act, as amended, or is currently determined, by the Arizona Department of Health Services as the CMS designee, to meet the requirements of certification.

"Interested party" means an actual or prospective offeror whose economic interest may be directly affected by the issuance of an RFP, the award of a contract, or by the failure to award a contract.

"Legal representative" means a custodial parent of a child under 18, a guardian, or a conservator.

"License" or "licensure" means a nontransferable authorization that is granted based on established standards in law by a state or a county regulatory agency or board and allows a health care provider to lawfully render a health care service.

"Mailing date" when used in reference to a document sent first class, postage prepaid, through the United States mail, means the date:

Shown on the postmark;

Shown on the postage meter mark of the envelope, if no postmark; or

Entered as the date on the document if there is no legible postmark or postage meter mark.

"Medical record" means a document that relates to medical or behavioral health services provided to a member by a physician or other licensed practitioner of the healing arts and is kept at the site of the provider.

"Medically necessary" means a covered service is provided by a physician or other licensed practitioner of the healing arts within the scope of practice under state law to prevent disease, disability, or other adverse health conditions or their progression, or to prolong life.

"Medicare claim" means a claim for Medicare-covered services for a member with Medicare coverage.

"Medicare HMO" means a health maintenance organization that has a current contract with Centers for Medicare and Medicaid Services for participation in the Medicare program under 42 CFR 417 Subpart L.

"Offeror" means an individual or entity that submits a proposal to the Administration in response to an RFP.

"Physician" means a person licensed as an allopathic or osteopathic physician under A.R.S. Title 32, Chapter 13 or Chapter 17.

"Practitioner" means a physician assistant licensed under A.R.S. Title 32, Chapter 25, or a certified nurse practitioner licensed under A.R.S. Title 32, Chapter 15.

"Prescription" means an order to provide covered services that is signed or transmitted by a provider authorized to prescribe the services.

"Primary care provider" or "PCP" means an individual who meets the requirements of A.R.S. § 36-2901(12) and (13), and who is responsible for the management of a member's health care.

"Prior authorization" means the process by which the Administration or contractor, whichever is applicable, authorizes, in advance, the delivery of covered services contingent on the medical necessity of the services.

"Prior period coverage" means the period prior to the member's enrollment during which a member is eligible for covered services. PPC begins on the first day of the month of application or the first eligible month, whichever is later, and continues until the day the member is enrolled with a contractor.

"Proposal" means all documents, including best and final offers, submitted by an offeror in response to an RFP by the Administration.

"Radiology" means professional and technical services rendered to provide medical imaging, radioisotope services, and radiation oncology.

"Referral" means the process by which a member is directed by a primary care provider or an attending physician to another appropriate provider or resource for diagnosis or treatment.

"Rehabilitation services" means physical, occupational, and speech therapies, and items to assist in improving or restoring a person's functional level.

"Responsible offeror" means an individual or entity that has the capability to perform the requirements of a contract and that ensures good faith performance.

"Responsive offeror" means an individual or entity that submits a proposal that conforms in all material respects to an RFP.

"Review" means a review of all factors affecting a member's eligibility.

"Review month" means the month in which the individual's or family's circumstances and case record are reviewed.

"RFP" means Request for Proposals, including all documents, whether attached or incorporated by reference, that are used by the Administration for soliciting a proposal under 9 A.A.C. 22, Article 6.

"Service location" means a location at which a member obtains a covered service provided by a physician or other licensed practitioner of the healing arts under the terms of a contract.

"Service site" means a location designated by a contractor as the location at which a member is to receive covered services.

"SOBRA" means Section 9401 of the Sixth Omnibus Budget Reconciliation Act, 1986, amended by the Medicare Catastrophic Coverage Act of 1988, 42 U.S.C. 1396a(a)(10)(A)(i)(IV), 42 U.S.C. 1396a(a)(10)(A)(i)(VI), and 42 U.S.C. 1396a(a)(10)(A)(i)(VII).

"Specialist" means a Board-eligible or certified physician who declares himself or herself as a specialist and practices a specific medical specialty. For the purposes of this definition, Board-eligible means a physician who meets all the requirements for certification but has not tested for, or has not been issued certification.

"Spouse" means a person who has entered into a contract of marriage recognized as valid by this state.

"SSN" means Social Security number.

"Standard of care" means a medical procedure or process that is accepted as treatment for a specific illness, injury, or medical condition through custom, peer review, or consensus by the professional medical community.

"Subcontract" means an agreement entered into by a contractor with any of the following:

A provider of health care services who agrees to furnish covered services to a member;,

A marketing organization;, or

Any other organization or person who agrees to perform any administrative function or service for the contractor specifically related to securing or fulfilling the contractor's obligation to the Administration under the terms of a

contract.

R9-22-102. ~~Scope of Services-related Definitions~~ Repealed

~~In addition to definitions contained in A.R.S. § 36-2901, the words and phrases in this Chapter have the following meanings unless the context explicitly requires another meaning:~~

~~"ADHS" means the Arizona Department of Health Services.~~

~~"Behavioral health recipient" means a Title XIX or Title XXI acute care member who is eligible for, and is receiving, behavioral health services through ADHS/DBHS.~~

~~"Children's Rehabilitative Services" or "CRS" means the program within ADHS that provides covered medical services and covered support services in accordance with A.R.S. § 36-261.~~

~~"Clinical supervision" means a Clinical Supervisor under 9 A.A.C. 20, Article 2 reviews the skills and knowledge of the individual supervised and provides guidance in improving or developing the skills and knowledge.~~

~~"Covered services" means the health and medical services described in Articles 2 and 12 of this Chapter as being eligible for reimbursement by AHCCCS.~~

~~"DBHS" means the Division of Behavioral Health Services within the Arizona Department of Health Services.~~

~~"Dentures" and "Denture services" mean a partial or complete set of artificial teeth and related services that are determined to be medically necessary and the primary treatment of choice, or an essential part of an overall treatment plan, and designed to alleviate a medical condition as determined by the primary care provider in consultation with the dental service provider.~~

~~"Diagnostic services" means services provided for the purpose of determining the nature and cause of a condition, illness, or injury.~~

~~"DME" means durable medical equipment, which is an item or appliance that can withstand repeated use, is designed to serve a medical purpose, and is not generally useful to a person in the absence of a medical condition, illness, or injury.~~

~~"Emergency behavioral health condition for the non-FES member" means a condition manifesting itself by acute symptoms of sufficient severity, including severe pain, such that a prudent layperson who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in:~~

1. ~~Placing the health of the person, including mental health, in serious jeopardy;~~
2. ~~Serious impairment to bodily functions;~~
3. ~~Serious dysfunction of any bodily organ or part; or~~
4. ~~Serious physical harm to another person.~~

~~"Emergency behavioral health services for the non-FES member" means those behavioral health services provided for the treatment of an emergency behavioral health condition.~~

~~"Emergency medical condition for the non-FES member" means treatment for a medical condition, including labor and delivery, that manifests itself by acute symptoms of sufficient severity, including severe pain, such that a prudent layperson who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:~~

1. ~~Placing the member's health in serious jeopardy;~~
2. ~~Serious impairment to bodily functions; or~~
3. ~~Serious dysfunction of any bodily organ or part.~~

~~"Emergency medical services for the non-FES member" means services provided for the treatment of an emergency medical condition.~~

~~"Fee-For-Service" or "FFS" means a method of payment by the AHCCCS Administration to a registered provider on an amount per service basis for a member not enrolled with a contractor.~~

~~"FES member" means a person who is eligible to receive emergency medical and behavioral health services through the FESP under R9-22-217.~~

~~"Hearing aid" means an instrument or device designed for, or represented by the supplier as, aiding or compensating for impaired or defective human hearing, and includes any parts, attachments, or accessories of the instrument or device.~~

~~"Home health services" means services and supplies that are provided by a home health agency that coordinates in-home intermittent services for curative, habilitative care, including home health aide services, licensed nurse services, and medical supplies, equipment, and appliances.~~

~~"IMD" or "Institution for Mental Diseases" means an Institution for Mental Diseases as described in 42 CFR 435.1010 and licensed by ADHS.~~

~~"Medical supplies" means consumable items that are designed specifically to meet a medical purpose.~~

~~"Non-FES member" means an eligible person who is entitled to full AHCCCS services.~~

~~"Occupational therapy" means medically prescribed treatment provided by or under the supervision of a licensed occupational therapist, to restore or improve an individual's ability to perform tasks required for independent functioning.~~

~~"Pharmaceutical service" means medically necessary medications that are prescribed by a physician, practitioner, or dentist under R9-22-209.~~

~~"Physical therapy" means treatment services to restore or improve muscle tone, joint mobility, or physical function provided by or under the supervision of a registered physical therapist.~~

~~"Physician" means a person licensed as an allopathic or osteopathic physician under A.R.S. Title 32, Chapter 13 or Chapter 17.~~

~~"Post-stabilization services" means covered services related to an emergency medical or behavioral health condition provided after the condition is stabilized.~~

~~"Practitioner" means a physician assistant licensed under A.R.S. Title 32, Chapter 25, or a certified nurse practitioner licensed under A.R.S. Title 32, Chapter 15.~~

~~"Prescription" means an order to provide covered services that is signed or transmitted by a provider authorized to prescribe the services.~~

~~"Primary care provider" or "PCP" means an individual who meets the requirements of A.R.S. § 36-2901(12) and (13), and who is responsible for the management of a member's health care.~~

~~"Primary care provider services" means healthcare services provided by and within the scope of practice, as defined by law, of a licensed physician, certified nurse practitioner, or licensed physician assistant.~~

~~"Prior authorization" means the process by which the Administration or contractor, whichever is applicable, authorizes, in advance, the delivery of covered services contingent on the medical necessity of the services.~~

~~"Psychosocial rehabilitation services" means services that provide education, coaching, and training to address or prevent residual functional deficits and may include services that may assist a member to secure and maintain employment. Psychosocial rehabilitation services may include:~~

~~Living skills training,~~

~~Cognitive rehabilitation,~~

~~Health promotion,~~

~~Supported employment, and~~

~~Other services that increase social and communication skills to maximize a member's ability to participate in the community and function independently.~~

~~"Radiology" means professional and technical services rendered to provide medical imaging, radioisotope services, and radiation oncology.~~

~~"RBHA" or "Regional Behavioral Health Authority" means the same as in A.R.S. § 36-3401.~~

~~"Rehabilitation services" means physical, occupational, and speech therapies, and items to assist in improving or restoring a person's functional level.~~

~~"Residual functional deficit" means a member's inability to return to a previous level of functioning, usually after experiencing a severe psychotic break or state of decompensation.~~

~~"Respiratory therapy" means treatment services to restore, maintain, or improve respiratory functions that are provided by, or under the supervision of, a respiratory therapist licensed according to A.R.S. Title 32, Chapter 35.~~

~~"Scope of services" means the covered, limited, and excluded services under Articles 2 and 12 of this Chapter.~~

~~"Specialist" means a Board-eligible or certified physician who declares himself or herself as a specialist and practices a specific medical specialty. For the purposes of this definition, Board-eligible means a physician who meets all the requirements for certification but has not tested for, or has not been issued certification.~~

~~"Speech therapy" means medically prescribed diagnostic and treatment services provided by, or under the supervision of, a certified speech therapist.~~

~~"Sterilization" means a medically necessary procedure, not for the purpose of family planning, to render an eligible person or member barren in order to:~~

~~Prevent the progression of disease, disability, or adverse health conditions; or~~

~~Prolong life and promote physical health.~~

~~"Substance abuse" means the chronic, habitual, or compulsive use of any chemical matter that, when introduced into the body, is capable of altering human behavior or mental functioning and, with extended use, may cause psychological dependence and impaired mental, social or educational functioning. Nicotine addiction is not considered substance abuse for adults who are 21 years of age or older.~~

R9-22-201. ~~General Requirements~~ Scope of Services-related Definitions

~~A.~~ ~~For the purposes of this Article, the following definitions apply:~~

~~1. "Authorization" means written or verbal authorization by:~~

~~a. The Administration for services rendered to a fee-for-service member or~~

~~b. The contractor for services rendered to a prepaid capitated member.~~

~~2. Use of the phrase "attending physician" applies only to the fee-for-service population.~~

~~B.~~ ~~In addition to other requirements and limitations specified in this Chapter, the following general requirements apply:~~

~~1. Only medically necessary, cost effective, and federally-reimbursable and state-reimbursable services are covered services.~~

~~2. Covered services for the federal emergency services program (FESP) are under R9-22-217.~~

~~3. The Administration or a contractor may waive the covered services referral requirements of this Article.~~

~~4. Except as authorized by the Administration or a contractor, a primary care provider, attending physician, practitioner, or a dentist shall provide or direct the member's covered services. Delegation of the provision of care to a practitioner does not diminish the role or responsibility of the primary care provider.~~

~~5. A contractor shall offer a female member direct access to preventive and routine services from gynecology providers within the contractor's network without a referral from a primary care provider.~~

~~6. A member may receive behavioral health evaluation services without a referral from a primary care provider. A member may receive behavioral health treatment services only under referral from the primary care provider, or upon authorization by the contractor or the contractor's designee.~~

~~7. A member may receive treatment that is considered the standard of care, or that is approved by the AHCCCS Chief Medical Officer after appropriate input from providers who are considered experts in the field by the professional medical community.~~

~~8. AHCCCS or a contractor shall provide services under the Section 1115 Waiver as defined in A.R.S. § 36-2901.~~

~~9. An AHCCCS registered provider shall provide covered services within the provider's scope of practice.~~

~~10. In addition to the specific exclusions and limitations otherwise specified under this Article, the following are not covered:~~

~~a. A service that is determined by the AHCCCS Chief Medical Officer to be experimental or provided primarily for the purpose of research;~~

~~b. Services or items furnished gratuitously, and~~

~~c. Personal care items.~~

~~11. Medical or behavioral health services are not covered services if provided to:~~

~~a. An inmate of a public institution;~~

~~b. A person who is in residence at an institution for the treatment of tuberculosis; or~~

~~c. A person age 21 through 64 who is in an IMD, unless provided under Article 12 of this Chapter.~~

~~C.~~ ~~The Administration or a contractor may deny payment of non-emergency services if prior authorization is not obtained as specified in this Article and Article 7 of this Chapter. The Administration or a contractor shall not reimburse services that require prior authorization unless the provider documents the diagnosis and treatment.~~

~~D.~~ ~~Services under A.R.S. § 36-2908 provided during the prior period coverage do not require prior authorization.~~

~~E.~~ ~~Prior authorization is not required for services necessary to evaluate and stabilize an emergency medical condition. The Administration or a contractor shall not reimburse services that require prior authorization unless the provider documents the diagnosis and treatment.~~

~~F.~~ ~~A service is not a covered service if provided outside the GSA unless one of the following applies:~~

~~1. A member is referred by a primary care provider for medical specialty care outside the GSA. If a member is referred outside the GSA to receive an authorized medically necessary service, the contractor shall also provide all other medically necessary covered services for the member;~~

~~2. There is a net savings in service delivery costs as a result of going outside the GSA that does not require undue travel time or hardship for a member or the member's family;~~

~~3. The contractor authorizes placement in a nursing facility located out of the GSA; or~~

~~4. Services are provided during prior period coverage.~~

~~G.~~ ~~If a member is traveling or temporarily residing outside of the GSA, covered services are restricted to emergency care services, unless otherwise authorized by the contractor.~~

~~**H.** A contractor shall provide at a minimum, directly or through subcontracts, the covered services specified in this Chapter and in contract.~~

~~**I.** The Administration shall determine the circumstances under which a FFS member may receive services, other than emergency services, from service providers outside the member's county of residence or outside the state. Criteria considered by the Administration in making this determination shall include availability and accessibility of appropriate care, and cost effectiveness.~~

~~**J.** The restrictions, limitations, and exclusions in this Article do not apply to the following:~~

~~1. Public and private employers selecting AHCCCS as a health care option for their employees according to 9 A.A.C. 27; and~~

~~2. A contractor electing to provide noncovered services.~~

~~a. The Administration shall not consider the costs of providing a noncovered service to a member in the development or negotiation of a capitation rate.~~

~~b. A contractor shall pay for noncovered services from administrative revenue or other contractor funds that are unrelated to the provision of services under this Chapter.~~

In addition to definitions contained in A.R.S. § 36-2901, the words and phrases in this Chapter have the following meanings unless the context explicitly requires another meaning:

"Behavioral health recipient" means a Title XIX or Title XXI acute care member who is eligible for, and is receiving, behavioral health services through ADHS/DBHS.

"Children's Rehabilitative Services" or "CRS" means the program within ADHS that provides covered medical services and covered support services in accordance with A.R.S. § 36-261.

"Clinical supervision" means a Clinical Supervisor under 9 A.A.C. 20, Article 2 reviews the skills and knowledge of the individual supervised and provides guidance in improving or developing the skills and knowledge.

"DBHS" means the Division of Behavioral Health Services within the Arizona Department of Health Services.

"Dentures" and "Denture services" mean a partial or complete set of artificial teeth and related services that are determined to be medically necessary and the primary treatment of choice, or an essential part of an overall treatment plan, and designed to alleviate a medical condition as determined by the primary care provider in consultation with the dental service provider.

"Emergency behavioral health condition for the non-FES member" means a condition manifesting itself by acute symptoms of sufficient severity, including severe pain, such that a prudent layperson who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in:

Placing the health of the person, including mental health, in serious jeopardy;

Serious impairment to bodily functions;

Serious dysfunction of any bodily organ or part; or

Serious physical harm to another person.

"Emergency behavioral health services for the non-FES member" means those behavioral health services provided for the treatment of an emergency behavioral health condition.

"Emergency medical condition for the non-FES member" means treatment for a medical condition, including labor and delivery, that manifests itself by acute symptoms of sufficient severity, including severe pain, such that a prudent layperson who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

Placing the member's health in serious jeopardy,

Serious impairment to bodily functions, or

Serious dysfunction of any bodily organ or part.

"Emergency medical services for the non-FES member" means services provided for the treatment of an emergency medical condition.

"Hearing aid" means an instrument or device designed for, or represented by the supplier as, aiding or compensating for impaired or defective human hearing, and includes any parts, attachments, or accessories of the instrument or device.

"Home health services" means services and supplies that are provided by a home health agency that coordinates in-home intermittent services for curative, habilitative care, including home-health aide services, licensed nurse services, and medical supplies, equipment, and appliances.

"IMD" or "Institution for Mental Diseases" means an Institution for Mental Diseases as described in 42 CFR 435.1010 and licensed by ADHS.

"Medical supplies" means consumable items that are designed specifically to meet a medical purpose.

"Non-FES member" means an eligible person who is entitled to full AHCCCS services.

"Occupational therapy" means medically prescribed treatment provided by or under the supervision of a licensed occupational therapist, to restore or improve an individual's ability to perform tasks required for independent functioning.

"Pharmaceutical service" means medically necessary medications that are prescribed by a physician, practitioner, or dentist under R9-22-209.

"Physical therapy" means treatment services to restore or improve muscle tone, joint mobility, or physical function provided by or under the supervision of a registered physical therapist.

"Post-stabilization services" means covered services related to an emergency medical or behavioral health condition provided after the condition is stabilized.

"Primary care provider services" means health care services provided by and within the scope of practice, as defined by law, of a licensed physician, certified nurse practitioner, or licensed physician assistant.

"Psychosocial rehabilitation services" means services that provide education, coaching, and training to address or prevent residual functional deficits and may include services that may assist a member to secure and maintain employment. Psychosocial rehabilitation services may include:

Living skills training,

Cognitive rehabilitation,

Health promotion,

Supported employment, and

Other services that increase social and communication skills to maximize a member's ability to participate in the community and function independently.

"RBHA" or "Regional Behavioral Health Authority" means the same as in A.R.S. § 36-3401.

"Residual functional deficit" means a member's inability to return to a previous level of functioning, usually after experiencing a severe psychotic break or state of decompensation.

"Respiratory therapy" means treatment services to restore, maintain, or improve respiratory functions that are provided by, or under the supervision of, a respiratory therapist licensed according to A.R.S. Title 32, Chapter 35.

"Scope of services" means the covered, limited, and excluded services under Articles 2 and 12 of this Chapter.

"Speech therapy" means medically prescribed diagnostic and treatment services provided by, or under the supervision of, a certified speech therapist.

"Sterilization" means a medically necessary procedure, not for the purpose of family planning, to render an eligible person or member barren in order to:

Prevent the progression of disease, disability, or adverse health conditions; or

Prolong life and promote physical health.

"Substance abuse" means the chronic, habitual, or compulsive use of any chemical matter that, when introduced into the body, is capable of altering human behavior or mental functioning and, with extended use, may cause psychological dependence and impaired mental, social or educational functioning. Nicotine addiction is not considered substance abuse for adults who are 21 years of age or older.

R9-22-202. ~~Repealed~~ General Requirements

A. For the purposes of this Article, the following definitions apply:
1. "Authorization" means written or verbal authorization by:
   a. The Administration for services rendered to a fee-for-service member, or
   b. The contractor for services rendered to a prepaid capitated member.
2. Use of the phrase "attending physician" applies only to the fee-for-service population.

B. In addition to other requirements and limitations specified in this Chapter, the following general requirements apply:
1. Only medically necessary, cost effective, and federally-reimbursable and state-reimbursable services are covered services.
2. Covered services for the federal emergency services program (FESP) are under R9-22-217.
3. The Administration or a contractor may waive the covered services referral requirements of this Article.
4. Except as authorized by the Administration or a contractor, a primary care provider, attending physician, practitioner, or a dentist shall provide or direct the member's covered services. Delegation of the provision of care to a practitioner does not diminish the role or responsibility of the primary care provider.

5. A contractor shall offer a female member direct access to preventive and routine services from gynecology providers within the contractor's network without a referral from a primary care provider.
6. A member may receive behavioral health evaluation services without a referral from a primary care provider. A member may receive behavioral health treatment services only under referral from the primary care provider, or upon authorization by the contractor or the contractor's designee.
7. A member may receive treatment that is considered the standard of care, or that is approved by the AHCCCS Chief Medical Officer after appropriate input from providers who are considered experts in the field by the professional medical community.
8. AHCCCS or a contractor shall provide services under the Section 1115 Waiver as defined in A.R.S. § 36-2901.
9. An AHCCCS registered provider shall provide covered services within the provider's scope of practice.
10. In addition to the specific exclusions and limitations otherwise specified under this Article, the following are not covered:
    a. A service that is determined by the AHCCCS Chief Medical Officer to be experimental or provided primarily for the purpose of research;
    b. Services or items furnished gratuitously, and
    c. Personal care items except as specified under R9-22-212.
11. Medical or behavioral health services are not covered services if provided to:
    a. An inmate of a public institution;
    b. A person who is in residence at an institution for the treatment of tuberculosis; or
    c. A person age 21 through 64 who is in an IMD, unless provided under Article 12 of this Chapter.

C. The Administration or a contractor may deny payment of non-emergency services if prior authorization is not obtained as specified in this Article and Article 7 of this Chapter. The Administration or a contractor shall not reimburse services that require prior authorization unless the provider documents the diagnosis and treatment.

D. Services under A.R.S. § 36-2908 provided during the prior period coverage do not require prior authorization.

E. Prior authorization is not required for services necessary to evaluate and stabilize an emergency medical condition. The Administration or a contractor shall not reimburse services that require prior authorization unless the provider documents the diagnosis and treatment.

F. A service is not a covered service if provided outside the GSA unless one of the following applies:
1. A member is referred by a primary care provider for medical specialty care outside the GSA. If a member is referred outside the GSA to receive an authorized medically necessary service, the contractor shall also provide all other medically necessary covered services for the member;
2. There is a net savings in service delivery costs as a result of going outside the GSA that does not require undue travel time or hardship for a member or the member's family;
3. The contractor authorizes placement in a nursing facility located out of the GSA; or
4. Services are provided during prior period coverage.

G. If a member is traveling or temporarily residing outside of the GSA, covered services are restricted to emergency care services, unless otherwise authorized by the contractor.

H. A contractor shall provide at a minimum, directly or through subcontracts, the covered services specified in this Chapter and in contract.

I. The Administration shall determine the circumstances under which a FFS member may receive services, other than emergency services, from service providers outside the member's county of residence or outside the state. Criteria considered by the Administration in making this determination shall include availability and accessibility of appropriate care, and cost effectiveness.

J. The restrictions, limitations, and exclusions in this Article do not apply to the following:
1. Public and private employers selecting AHCCCS as a health care option for their employees according to 9 A.A.C. 27; and
2. A contractor electing to provide noncovered services.
    a. The Administration shall not consider the costs of providing a noncovered service to a member in the development or negotiation of a capitation rate.
    b. A contractor shall pay for noncovered services from administrative revenue or other contractor funds that are unrelated to the provision of services under this Chapter.

R9-22-217. Services Included in the Federal Emergency Services Program

A. Definition. For the purposes of this Section, an emergency medical or behavioral health condition for a FES member means a medical condition or a behavioral health condition, including labor and delivery, manifesting itself by acute symptoms of sufficient severity, including severe pain, such that the absence of immediate medical attention could reasonably be expected to result in:
1. Placing the member's health in serious jeopardy,
2. Serious impairment to bodily functions,

3. Serious dysfunction of any bodily organ or part, or
4. Serious physical harm to another person.

B. Services. Emergency services for a FES member mean those medical or behavioral health services provided for the treatment of an emergency condition. Emergency services include outpatient dialysis services for an FES member with End Stage Renal Disease (ESRD) where a treating physician has certified that in his opinion the absence of receiving dialysis at least three times per week would reasonably be expected to result in:

1. Placing the patient's health in serious jeopardy; or
2. Serious impairment of bodily function; or
3. Serious dysfunction of a bodily organ or part.

C. Covered services. Services are considered emergency services if all of the criteria specified in subsection (A) are satisfied at the time the services are rendered and timely notification as specified in subsection (E) is given. The Administration shall determine whether an emergency condition exists on a case-by-case basis.

D. Prior authorization. A provider is not required to obtain ~~Prior~~ prior authorization ~~is not required~~ for emergency services for FES members. The Administration shall issue a prior authorization for outpatient dialysis services when the treating physician has completed and signed a monthly certification as described in subsection (B).

E. Notification. A provider shall notify the Administration no later than 72 hours after a FES member receiving emergency medical or behavioral health services presents to a hospital for inpatient services. The Administration may deny payment for failure to provide timely notice.

NOTICE OF PROPOSED RULEMAKING

TITLE 9. HEALTH SERVICES

CHAPTER 22. ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM ADMINISTRATION

[R07-103]

PREAMBLE

1. Sections Affected — **Rulemaking Action**

R9-22-212	Amend
R9-22-213	Amend
R9-22-216	Amend

2. The statutory authority for the rulemaking, including both the authorizing statute (general) and the statutes the rules are implementing (specific):

Authorizing statute: A.R.S. § 36-2903.01(F)

Implementing statute: A.R.S § 36-2907

3. A list of all previous notices appearing in the *Register* addressing the proposed rule:

Notice of Rulemaking Docket Opening: 12 A.A.R. 1422, April 28, 2006

4. The name and address of agency personnel with whom persons may communicate regarding the rulemaking:

Name: Mariaelena Ugarte

Address: AHCCCS
Office of Legal Assistance
701 E. Jefferson, Mail Drop 6200
Phoenix, AZ 85034

Telephone: (602) 417-4693

Fax: (602) 253-9115

E-mail: AHCCCSRules@azahcccs.gov

5. An explanation of the rule, including the agency's reasons for initiating the rule:

The Administration must revise rules to comply with the Consent Decree mandating the coverage of incontinence briefs as a preventive measure to certain E.P.S.D.T. AHCCCS members who are incontinent as a result of their disabilities.

6. A reference to any study that the agency proposes to rely on in its evaluation of or justification for the rules and

where the public may obtain or review the study, all data underlying each study, any analysis of the study, and other supporting material:

No study was reviewed or considered for this rulemaking.

7. A showing of good cause why the rule is necessary to promote a statewide interest if the rule will diminish a previous grant of authority of a political subdivision of this state:

Not applicable

8. The preliminary summary of the economic, small business, and consumer impact:

This rulemaking is anticipated to have a minimal to moderate economic impact on the involved parties. Affected members will benefit from the added coverage of incontinence briefs. Additional costs will be incurred by the Administration and the contractors for coverage of these supplies.

9. The name and address of agency personnel with whom persons may communicate regarding the accuracy of the economic, small business, and consumer impact statement:

Name: Mariaelena Ugarte

Address: AHCCCS
Office of Legal Assistance
701 E. Jefferson, Mail Drop 6200
Phoenix, AZ 85034

Telephone: (602) 417-4693

Fax: (602) 253-9115

E-mail: AHCCCSRules@azahcccs.gov

Proposed rule language will be available on the AHCCCS web site www.azahcccs.gov the week of April 2, 2007. Please send written comments to the above address by 5:00 p.m., May 21, 2007. E-mail comments will be accepted.

10. The time, place, and nature of the proceedings for the making, amendment, or repeal of the rule, or if no proceeding is scheduled, where, when, and how persons may request an oral proceeding on the proposed rule:

Date: May 21, 2007
Time: 10:00 a.m.
Location: AHCCCS
701 E. Jefferson
Phoenix, AZ 85034
Nature: Public Hearing

Date: May 21, 2007
Time: 10:00 a.m.
Location: ALTCS: Arizona Long-term Care System
110 S. Church, Ste. 1360
Tucson, AZ 85701
Nature: Public Hearing

Date: May 21, 2007
Time: 10:00 a.m.
Location: ALTCS: Arizona Long-term Care System
3480 E. Rte. 66
Flagstaff, AZ 86004
Nature: Public Hearing

11. Any other matters prescribed by statute that are applicable to the specific agency or to any specific rule or class of rules:

None

12. Incorporations by reference and their location in the rules:

None

13. The full text of the rules follows:

TITLE 9. HEALTH SERVICES

CHAPTER 22. ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM

ADMINISTRATION

ARTICLE 2. SCOPE OF SERVICES

Section
R9-22-212. ~~Medical Supplies,~~ Durable Medical Equipment, ~~and~~ Orthotic and Prosthetic Devices, and Medical Supplies
R9-22-213. Early and Periodic Screening, Diagnosis, and Treatment Services (E.P.S.D.T.)
R9-22-216. NF, Alternative HCBS Setting, or HCBS

ARTICLE 2. SCOPE OF SERVICES

R9-22-212. ~~Medical Supplies,~~ Durable Medical Equipment, ~~and~~ Orthotic and Prosthetic Devices, and Medical Supplies

A. ~~Medical supplies, durable~~ Durable medical equipment, ~~and~~ orthotic and prosthetic devices, and medical supplies, including incontinence briefs as specified in subsection (E), are covered services if provided in compliance with requirements of this Chapter, and
1. Prescribed by the primary care provider, attending physician, practitioner, or dentist;
2. Prescribed by a specialist, upon referral from the primary care provider; attending physician, practitioner or dentist; and
3. Authorized as required by the Administration, contractor, or contractor's designee.

B. Covered medical supplies are consumable items that are disposable and are essential for the member's health.

C. Covered DME is any item, appliance, or piece of equipment that is:
1. Designed for a medical purpose,
2. To withstand wear,
3. Generally reusable by others, and
4. Purchased or rented for a member.

D. Covered prosthetic and orthotic devices are only those items that are essential for the habilitation or rehabilitation of a member.

E. The following limitations on coverage apply:
1. The DME is furnished on a rental or purchase basis, whichever is less expensive. The total expense of renting the DME does not exceed the cost of the DME if purchased.
2. Reasonable repair or adjustment of purchased DME is covered if necessary to make the DME serviceable and if the cost of repair is less than the cost of renting or purchasing another unit.
3. A change in, or addition to, an original order for DME is covered if approved by the member's primary care provider or authorized prescriber, or prior authorized by the Administration or contractor, and the change or addition is indicated clearly on the order and initialed by the vendor. No change or addition to the original order for DME may be made after a claim for services is submitted to the member's contractor, or the Administration, without prior written notification of the change or addition.
4. Reimbursement for rental fees shall terminate:
   a. No later than the end of the month in which the primary care provider or authorized prescriber certifies that the member no longer needs the DME;
   b. If the member is no longer eligible for AHCCCS services; or
   c. If the member is no longer enrolled with a contractor, with the exception of transitions of care as specified by the Administration.
5. ~~Personal~~ Except for incontinence briefs as provided in subsection (E)(6), personal incidentals including items for personal cleanliness, body hygiene, and grooming are not covered unless needed to treat a medical condition. ~~and:~~
   ~~a. Prescribed by:~~
      ~~i. The member's primary care provider, attending physician, practitioner;~~
      ~~ii. A specialist upon referral from the primary care provider, attending physician, or practitioner; and~~
   ~~b. Authorized as required by the Administration, or contractor or its designee.~~
6. Incontinence briefs, including pull-ups are covered in order to prevent skin breakdown and to enable participation in social, community, therapeutic and educational activities under the following circumstances:
   a. The member is over 3 years and under 21 years old;
   b. The member is incontinent due to a documented disability that causes incontinence of bowel and/or bladder;
   c. The PCP or attending physician has issued a prescription ordering the incontinence briefs;
   d. Incontinence briefs do not exceed 240 briefs per month unless the prescribing physician presents evidence of medical necessity for more than 240 briefs per month for a member diagnosed with chronic diarrhea or spastic bladder.
   e. The member obtains incontinence briefs from providers in the Contractor's network.

f. Prior authorization has been obtained as required by the Administration, contractor, or contractor's designee. Contractors may require a new prior authorization to be issued more frequently than every twelve months. Prior authorization for a renewal of an existing prescription may be provided by the physician through telephone contact with the member rather than an in-person physician visit. Prior authorization will be permitted to ascertain that:
   i. The member is over age 3 and under age 21;
   ii. The member has a disability that causes incontinence of bladder and bowel;
   iii. A physician has prescribed incontinence briefs as medically necessary. A physician prescription supporting medical necessity may be required for specialty briefs or for briefs different from the standard briefs supplied by the contractor; and
   iv. The prescription is for 240 briefs or fewer per month, unless evidence of medical necessity for over 240 briefs is provided.

~~6.~~ 7. First aid supplies are not covered unless they are provided in accordance with a prescription.
~~7.~~ 8. Hearing aids are not covered for a member who is age 21 or older.
~~8.~~ 9. Prescriptive lenses are not covered for a member who is age 21 or older unless they are the sole visual prosthetic device used by the member after a cataract extraction.

F. Liability and ownership.
1. Purchased DME provided to a member that is no longer needed may be disposed of in accordance with each contractor's policy.
2. The Administration shall retain title to purchased DME supplied to a member who becomes ineligible or no longer requires its use.
3. If customized DME is purchased by the Administration or contractor for a member, the equipment shall remain with the person during times of transition, or upon loss of eligibility.
   a. For purposes of this Section, customized DME refers to equipment that is altered or built to specifications unique to a member's medical needs and that, most likely, cannot be used or reused to meet the needs of another individual.
   b. A member shall return customized DME obtained fraudulently to the Administration or the contractor.

R9-22-213. Early and Periodic Screening, Diagnosis, and Treatment Services (E.P.S.D.T.)

A. The following E.P.S.D.T. services are covered for a member less than 21 years of age:
1. Screening services including:
   a. Comprehensive health and developmental history;
   b. Comprehensive unclothed physical examination;
   c. Appropriate immunizations according to age and health history;
   d. Laboratory tests; and
   e. Health education, including anticipatory guidance;
2. Vision services including:
   a. Diagnosis and treatment for defects in vision;
   b. Eye examinations for the provision of prescriptive lenses; and
   c. Provision of prescriptive lenses;
3. Hearing services including:
   a. Diagnosis and treatment for defects in hearing;
   b. Testing to determine hearing impairment; and
   c. Provision of hearing aids;
4. Dental services including:
   a. Emergency dental services as specified in R9-22-207;
   b. Preventive services including screening, diagnosis, and treatment of dental disease; and
   c. Therapeutic dental services including fillings, crowns, dentures, and other prosthetic devices;
5. Orthognathic surgery;
6. Nutritional assessment and nutritional therapy as specified in contract to provide complete daily dietary requirements or supplement a member's daily nutritional and caloric intake;
7. Behavioral health services under 9 A.A.C. 22, Article 12;
8. Hospice services as follows:
   a. Hospice services are covered only for a member who is in the final stages of a terminal illness and has a prognosis of death within six months;
   b. Services available to a member receiving hospice care are limited to those allowable under 42 CFR 418.202, December 20, 1994, incorporated by reference and on file with the Administration and the Office of the Secretary of State. This incorporation by reference contains no future editions or amendments; and
   c. Hospice services do not include:

i. Medical services provided that are not related to the terminal illness; or
ii. Home delivered meals.
d. Hospice services that are provided and covered through Medicare are not covered by AHCCCS.

9. Incontinence briefs as specified under R9-22-212.

~~9.~~ 10. Other necessary health care, diagnostic services, treatment, and measures required by 42 U.S.C. 1396d(r)(5).

B. Providers of E.P.S.D.T. services shall meet the following standards:
1. Provide services by or under the direction of the member's primary care provider, attending physician, practitioner, or dentist.
2. Perform tests and examinations under 42 CFR 441 Subpart B, January 29, 1985, which is incorporated by reference and on file with the Office of the Secretary of State and the Administration. This incorporation by reference contains no future editions or amendments.
3. Refer a member as necessary for dental diagnosis and treatment and necessary specialty care.
4. Refer a member as necessary for behavioral health evaluation and treatment services.

C. Contractors shall meet other E.P.S.D.T. requirements as specified in contract.

D. A primary care provider, attending physician, or practitioner shall refer a member with special health care needs under R9-7-301 to CRS.

R9-22-216. NF, Alternative HCBS Setting, or HCBS

A. Services provided in a NF, including room and board, alternative HCBS setting as defined in R9-28-101, or HCBS as defined in R9-28-101 are covered for a maximum of 90 days per contract year if the member's medical condition would otherwise require hospitalization.

B. Except as otherwise provided in 9 A.A.C. 28, the following services are not itemized for separate billing if provided in a NF, alternative HCBS setting, or HCBS:
1. Nursing services including:
a. Administering medication,
b. Tube feedings,
c. Personal care service (assistance with bathing and grooming),
d. Routine testing of vital signs, and
e. Maintenance of catheter;
2. Basic patient care equipment and sickroom supplies including:
a. First aid supplies such as bandages, tape, ointments, peroxide, alcohol, and over-the-counter remedies;
b. Bathing and grooming supplies;
c. Identification device;
d. Skin lotion;
e. Medication cup;
f. Alcohol wipes, cotton balls, and cotton rolls;
g. Rubber gloves (non-sterile);
h. Laxatives;
i. Bed and accessories;
j. Thermometer;
k. Ice bags;
l. Rubber sheeting;
m. Passive restraints;
n. Glycerin swabs;
o. Facial tissue;
p. Enemas;
q. Heating pad;
r. ~~Diapers~~ Incontinence briefs; and
s. Alcoholic beverages;
3. Dietary services including preparation and administration of special diets, and adaptive tools for eating;
4. Any service that is included in a NF's room and board charge or a service that is required of the NF to meet a federal, state licensure standard, or county certification requirement;
5. Physician visits made solely for the purpose of meeting state licensure standards or county certification requirements;
6. Physical therapy prescribed only as a maintenance regimen; and
7. Assistive devices or non-customized durable medical equipment.

C. A provider shall obtain prior authorization from the Administration for a NF admission for a FFS member.

NOTICE OF PROPOSED RULEMAKING

TITLE 9. HEALTH SERVICES

CHAPTER 31. ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM CHILDREN'S HEALTH INSURANCE PROGRAM

[R07-104]

PREAMBLE

1. Sections Affected — **Rulemaking Action**

R9-31-201	Amend
R9-31-212	Amend
R9-31-216	Amend
R9-31-1611	Amend

2. The statutory authority for the rulemaking, including both the authorizing statute (general) and the statutes the rules are implementing (specific):

Authorizing statute: A.R.S. § 36-2903.01(F)

Implementing statute: A.R.S. § 36-2989

3. A list of all previous notices appearing in the *Register* addressing the proposed rule:

Notice of Rulemaking Docket Opening: 12 A.A.R. 1424, April 28, 2006

4. The name and address of agency personnel with whom persons may communicate regarding the rulemaking:

Name: Mariaelena Ugarte

Address: AHCCCS
Office of Legal Assistance
701 E. Jefferson, Mail Drop 6200
Phoenix, AZ 85034

Telephone: (602) 417-4693

Fax: (602) 253-9115

E-mail: AHCCCSRules@azahcccs.gov

5. An explanation of the rule, including the agency's reasons for initiating the rule:

The Administration must revise rules to comply with the Consent Decree mandating the coverage of incontinence briefs as a preventive measure to certain E.P.S.D.T. AHCCCS members who are incontinent as a result of their disabilities.

6. A reference to any study that the agency proposes to rely on in its evaluation of or justification for the rules and where the public may obtain or review the study, all data underlying each study, any analysis of the study, and other supporting material:

No study was reviewed or considered for this rulemaking.

7. A showing of good cause why the rule is necessary to promote a statewide interest if the rule will diminish a previous grant of authority of a political subdivision of this state:

Not applicable

8. The preliminary summary of the economic, small business, and consumer impact:

This rulemaking is anticipated to have a minimal to moderate economic impact on the involved parties. Affected members will benefit from the added coverage of incontinence briefs. Additional costs will be incurred by the Administration and the contractors for coverage of these supplies.

9. The name and address of agency personnel with whom persons may communicate regarding the accuracy of the economic, small business, and consumer impact statement:

Name: Mariaelena Ugarte

Address: AHCCCS
Office of Legal Assistance
701 E. Jefferson, Mail Drop 6200
Phoenix, AZ 85034

Telephone: (602) 417-4693

Fax: (602) 253-9115

E-mail: AHCCCSRules@azahcccs.gov

Proposed rule language will be available on the AHCCCS web site www.azahcccs.gov the week of April 2, 2007. Please send written comments to the above address by 5:00 p.m., May 21, 2007. E-mail comments will be accepted.

10. The time, place, and nature of the proceedings for the making, amendment, or repeal of the rule, or if no proceeding is scheduled, where, when, and how persons may request an oral proceeding on the proposed rule:

Date: May 21, 2007
Time: 10:00 a.m.
Location: AHCCCS
701 E. Jefferson
Phoenix, AZ 85034
Nature: Public Hearing

Date: May 21, 2007
Time: 10:00 a.m.
Location: ALTCS: Arizona Long-term Care System
110 S. Church, Ste. 1360
Tucson, AZ 85701
Nature: Public Hearing

Date: May 21, 2007
Time: 10:00 a.m.
Location: ALTCS: Arizona Long-term Care System
3480 E. Rte. 66
Flagstaff, AZ 86004
Nature: Public Hearing

11. Any other matters prescribed by statute that are applicable to the specific agency or to any specific rule or class of rules:

None

12. Incorporations by reference and their location in the rules:

None

13. The full text of the rules follows:

TITLE 9. HEALTH SERVICES

CHAPTER 31. ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM CHILDREN'S HEALTH INSURANCE PROGRAM

ARTICLE 2. SCOPE OF SERVICES

Section
R9-31-201. General Requirements
R9-31-212. ~~Medical Supplies,~~ Durable Medical Equipment, ~~and~~ Orthotic and Prosthetic Devices, and Medical Supplies
R9-31-216. NF, Alternative HCBS Setting, or HCBS

ARTICLE 16. SERVICES FOR NATIVE AMERICANS

Section
R9-31-1611. ~~Medical Supplies,~~ Durable Medical Equipment, ~~and~~ Orthotic and Prosthetic Devices, and Medical Supplies

ARTICLE 2. SCOPE OF SERVICES

R9-31-201. General Requirements

A. The Administration shall administer the Children's Health Insurance Program under A.R.S. § 36-2982.
B. Scope of Services for Native American fee-for-service members is under Article 16 of this Chapter.
C. A contractor or RBHA shall provide behavioral health services under Article 12 and Article 16.
D. In addition to other requirements and limitations specified in this Chapter, the following general requirements apply:

1. Only medically necessary, cost effective, and federally-reimbursable and state-reimbursable services are covered services.
2. The Administration or a contractor may waive the covered services referral requirements of this Article.
3. Except as authorized by a contractor, a primary care provider, practitioner, or dentist shall provide or direct the member's covered services. Delegation of the provision of care to a practitioner does not diminish the role or responsibility of the primary care provider.
4. A contractor shall offer a female member direct access to preventive and routine services from gynecology providers within the contractor's network without a referral from a primary care provider.
5. A member may receive behavioral health evaluation services without a referral from a primary care provider. A member may receive behavioral health treatment services only under referral from the primary care provider, or upon authorization by the contractor or the contractor's designee.
6. A member may receive treatment that is considered the standard of care, or that is approved by the AHCCCS Chief Medical Officer after appropriate input from providers who are considered experts in the field by the professional medical community.
7. An AHCCCS registered provider shall provide covered services within the provider's scope of practice.
8. In addition to the specific exclusions and limitations otherwise specified under this Article, the following are not covered:
   a. A service that is determined by the AHCCCS Chief Medical Officer to be experimental or provided primarily for the purpose of research,
   b. Services or items furnished gratuitously, and
   c. Personal care items, except as specified in R9-31-212.
9. Medical or behavioral health services are not covered if provided to:
   a. An inmate of a public institution;
   b. A person who is a resident of an institution for the treatment of tuberculosis; or
   c. A person who is in an IMD at the time of application, unless provided under Article 12 of this Chapter.

E. The Administration or a contractor may deny payment of non-emergency services if prior authorization is not obtained under this Article and Article 7 of this Chapter. The Administration or a contractor shall not reimburse services that require prior authorization unless the provider documents the diagnosis and treatment.

F. Prior authorization is not required for services necessary to evaluate and stabilize an emergency medical condition. The Administration or a contractor shall not reimburse services that require prior authorization unless the provider documents the diagnosis and treatment.

G. Under A.R.S. § 36-2989, a member shall receive covered services outside the GSA only if one of the following applies:
1. A member is referred by a primary care provider for medical specialty care out of the contractor's area. If the member is referred outside of the GSA to receive an authorized medically necessary service, a contractor shall also provide all other medically necessary covered services for the member;
2. There is a net savings in service delivery costs as a result of going outside the GSA that does not require undue travel time or hardship for a member or the member's family; or
3. The contractor authorizes placement in a nursing facility located outside of the GSA;

H. If a member is traveling or temporarily residing outside of the GSA, covered services are restricted to emergency care services, unless otherwise authorized by the contractor.

I. A contractor shall provide at a minimum, directly or through subcontracts, the covered services specified in this Chapter and in contract.

J. The restrictions, limitations, and exclusions in this Article do not apply to a contractor if the contractor elects to provide noncovered services.
1. The Administration shall not consider the costs of providing a noncovered service to a member in the development or negotiation of a capitation rate.
2. A contractor shall pay for noncovered services from administrative revenue or other contractor funds that are unrelated to the provision of services under this Chapter.

R9-31-212. ~~Medical Supplies,~~ Durable Medical Equipment, ~~and~~ Orthotic and Prosthetic Devices, and Medical Supplies

~~A.~~ As specified in A.R.S. § 36-2989, ~~medical supplies,~~ DME, ~~and~~ orthotic and prosthetic devices, and medical supplies, including incontinence briefs, are covered services if provided in compliance with requirements of this Chapter and~~:~~ A.A.C. R9-22-212. Where the term AHCCCS services is used, replace it with Title XXI services.
~~1. Prescribed by the member's primary care provider, practitioner, or dentist;~~
~~2. Prescribed by a specialist upon referral from the primary care provider, practitioner, or dentist; and~~
~~3. Authorized by the contractor or the contractor's designee.~~

~~B.~~ ~~Covered medical supplies are consumable items that are disposable and are essential to a member's health.~~

~~C.~~ ~~Covered DME is any item, appliance, or piece of equipment that is:~~

1. ~~Designed for a medical purpose,~~
2. ~~To withstand wear,~~
3. ~~Generally reusable by others, and~~
4. ~~Purchased or rented for a member.~~

~~**D.** Covered prosthetic and orthotic devices are only those items that are essential for the habilitation or rehabilitation of a member.~~

~~**E.** The following limitations on coverage include:~~

1. ~~DME is furnished on a rental or purchase basis, whichever is less expensive. The total expense of renting the DME does not exceed the cost of the DME if purchased;~~
2. ~~Reasonable repair or adjustment of purchased DME is covered if necessary to make the DME serviceable and if the cost of repair is less than the cost of renting or purchasing another unit;~~
3. ~~A change in, or addition to, an original order for DME is covered if approved by the member's primary care provider or authorized prescriber, or prior authorized by the contractor for a member, and the change or addition is indicated clearly on the order and initialed by the vendor. No change or addition to the original order for DME shall be made after a claim for services is submitted to a member's contractor, without prior written notification of the change or addition;~~
4. ~~Reimbursement for rental fees shall terminate:~~
   a. ~~No later than the end of the month in which the primary care provider or authorized prescriber certifies that the member no longer needs the DME;~~
   b. ~~If the member is no longer eligible for AHCCCS services; or~~
   c. ~~If the member is no longer enrolled with a contractor, with the exception of transitions of care as specified by the Administration.~~
5. ~~Personal incidentals including items for personal cleanliness, body hygiene, and grooming are not covered unless needed to treat a medical condition and:~~
   a. ~~Prescribed by:~~
      i. ~~The member's primary care provider or practitioner, or~~
      ii. ~~A specialist upon referral from the primary care provider or practitioner; and~~
   b. ~~Authorized as required by the contractor or its designee;~~
6. ~~First aid supplies are not covered unless they are provided in accordance with a prescription.~~

~~**F.** Liability and ownership.~~

1. ~~Purchased DME provided to a member that is no longer needed may be disposed of in accordance with each contractor's policy.~~
2. ~~If customized DME is purchased by the contractor for a member, the DME shall remain with the member during times of transition, or upon loss of eligibility.~~
   a. ~~For purposes of this Section, customized DME refers to DME that has been altered or built to specifications unique to a member's medical needs and that, most likely, cannot be used or reused to meet the needs of another individual.~~
   b. ~~A member shall return customized DME obtained fraudulently to the Administration or the contractor.~~

R9-31-216. NF, Alternative HCBS Setting, or HCBS

~~**A.**~~ Services provided in a NF, including room and board, alternative HCBS setting, or HCBS ~~as defined in R9-28-101, or HCBS as defined in R9-28-101 are covered for a maximum of 90 days per contract year if the member's medical condition would otherwise require hospitalization.~~ shall be covered as specified in A.A.C. R9-22-216.

~~**B.** Except as otherwise provided in 9 A.A.C. 28, the following services are not itemized for separate billing if provided in a NF, alternative HCBS setting, or HCBS:~~

1. ~~Nursing services including:~~
   a. ~~Administering medication,~~
   b. ~~Tube feedings,~~
   c. ~~Personal care services (assistance with bathing and grooming),~~
   d. ~~Routine testing of vital signs, and~~
   e. ~~Maintenance of catheter.~~
2. ~~Basic patient care equipment and sickroom supplies, including:~~
   a. ~~First aid supplies such as bandages, tape, ointment, peroxide, alcohol, and over-the-counter remedies;~~
   b. ~~Bathing and grooming supplies;~~
   c. ~~Identification device;~~
   d. ~~Skin lotion;~~
   e. ~~Medication cup;~~
   f. ~~Alcohol wipes, cotton balls, and cotton rolls;~~
   g. ~~Rubber gloves (non-sterile);~~

~~h. Laxatives;~~
~~i. Bed and accessories;~~
~~j. Thermometer;~~
~~k. Ice bags;~~
~~l. Rubber sheeting;~~
~~m. Passive restraints;~~
~~n. Glycerin swabs;~~
~~o. Facial tissue;~~
~~p. Enemas;~~
~~q. Heating pad; and~~
~~r. Diapers.~~

~~3. Dietary services including preparation and administration of special diets, and adaptive tools for eating;~~
~~4. Any service that is included in a NF's room and board charge or a service that is required of the NF to meet a federal mandate, state licensure standard, or county certification requirement;~~
~~5. Physician visits made solely for the purpose of meeting a state licensure standard or county certification requirement;~~
~~6. Physical therapy; and~~
~~7. Assistive device or non-customized DME.~~

ARTICLE 16. SERVICES FOR NATIVE AMERICANS

R9-31-1611. ~~Medical Supplies,~~ Durable Medical Equipment, ~~and~~ Orthotic and Prosthetic Devices, and Medical Supplies

~~A.~~ ~~Medical supplies, DME~~ Durable medical equipment, ~~and~~ orthotic and prosthetic devices, and medical supplies, including incontinence briefs, are covered services if provided in compliance with the requirements of this Chapter~~;~~ and A.A.C. R9-22-212. Where the term AHCCCS services is used, replace it with Title XXI services. Where the term provider or contractor is used, replace it with IHS or Tribal facility.

~~1. Authorized by the Administration,~~
~~2. Prescribed by the IHS or Tribal Facility provider, or~~
~~3. Prescribed by a physician or a practitioner upon referral from the IHS or a Tribal Facility unless the referral is waived by the Administration.~~

~~B. Covered medical supplies are consumable items that are disposable and are essential to a member's health.~~

~~C. Covered DME is any item, appliance, or piece of equipment that is:~~

~~1. Designed for a medical purpose,~~
~~2. To withstand wear,~~
~~3. Generally reusable by others, and~~
~~4. Purchased or rented for a member.~~

~~D. Covered prosthetic and orthotic devices are only those items that are essential for the habilitation or rehabilitation of a member.~~

~~E. The following limitations on coverage apply:~~

~~1. DME is furnished on a rental or purchase basis, whichever is less expensive. The total expense of renting the DME does not exceed the cost of the DME if purchased.~~
~~2. Reasonable repair or adjustment of purchased DME is covered if necessary to make the DME serviceable and if the cost of repair is less than the cost of renting or purchasing another unit.~~
~~3. A change in, or addition to, an original order for DME is covered if approved by a member's IHS or a Tribal Facility provider or an authorized prescriber and the change or addition is indicated clearly on the order and initialed by a vendor.~~
~~4. Reimbursement for rental fees shall terminate:~~
~~a. No later than the end of the month in which the IHS or a Tribal Facility provider or an authorized prescriber certifies that the member no longer needs the DME,~~
~~b. If the member is no longer eligible for service through this program, or~~
~~c. If the member is no longer enrolled with the IHS with the exception of transitions of care as specified by the Administration.~~
~~5. Personal incidentals including items for personal cleanliness, body hygiene, and grooming are not covered unless needed to treat a medical condition and:~~
~~a. Prescribed by:~~
~~i. The member's attending physician or practitioner, or~~
~~ii. A specialist upon referral from an IHS or tribal facility provider, and~~
~~b. Authorized as required by the Administration.~~
~~6. First aid supplies are not covered unless they are provided according to a prescription.~~

~~**F.** Liability and ownership.~~
~~1. Purchased DME provided to a member that is no longer needed may be disposed of as specified in the policy of the IHS or a Tribal Facility.~~
~~2. If customized DME is purchased for a member by the Administration, the DME shall remain with the member during times of transition, or upon loss of eligibility.~~
~~a. For purposes of this Section, customized DME refers to DME that has been altered or built to specifications unique to a member's medical needs and that, most likely, cannot be used or reused to meet the needs of another individual.~~
~~b. A member shall return customized equipment obtained fraudulently to the Administration.~~